

# **Delivering a responsive and effective specialist community palliative care service in an environment of change.**

An economic assessment of innovations made within the community nurse specialist team at UoA & Co. A.P. [ • ] & A.

By Vanessa Gibson

## **Abstract**

### **Background**

Specialist palliative care services face many challenges not least projected demographic changes, an increasing demand to widen their services to any patient with a life limiting diagnosis and on-going restructuring of statutory services.

This paper aims to explore the impact of a range of innovations introduced within a community specialist palliative care team in response to escalating demands upon the service.

### **Method**

The impact of three key innovations was explored. Direct comparisons pre and post innovations where undertaken where possible and wider literature explored to enhance understanding of the wider implications of changes made to practice.

### **Findings**

Innovations introduced incurred limited set up and running costs, however they released a significant amount of clinical nurse specialist time which could then be redeployed to support patients with the most complex needs.

### **Conclusion**

Practical benefits for the clinical nurse specialist service, patients, general practitioners and the local acute hospital are clear, however further work is required to enhance team resilience and reduce the risk of burnout. This is of particular importance as team efforts are now much more focused upon patients with the most complex needs.

## **Background**

This paper aims to explore the economic impact of a range of interventions introduced by the community nurse specialist team. The paper has been written to demonstrate to the community nurse specialist team and senior management team the value of these interventions in terms of both cost avoidance and more effective use of current resources.

Specialist palliative care services are facing many challenges not least a drive to broaden access to their services for people with wide ranging diagnoses.





Proactive caseload management	Capped caseloads (7 patients per day worked) Introduction of a waiting list Introduction of dependency monitoring Development of geographical teams Improved data collection
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## Assessing the impact

To assess the impact of the innovations an economic assessment was carried out. This economic assessment focused upon:

- Set up and on-going running costs
- This included direct costs i.e. additional equipment and indirect costs i.e. additional input from supporting departments including the admin team
- Cost and time avoidance for specific innovations
- Implications outside the organisation for example costs avoided by potential admission avoidance

The economic assessment focused on the impacts across a range of stakeholders:

### For those using the service

The service aims to offer a co-ordinated and responsive service

the patient by a member of the triage team and as a result a total of 30 first assessment visits have been prevented.

The economic benefits of the prevention of unnecessary first visits are summarised in box 1: Costs are based solely on CNS salary costs.

However rather than simply being a cost saving this change in practice has resulted in more effective resource allocation. Time saved by the CNS team in not undertaking unnecessary first visits provides totals 135 hours over a 4 month period. Over a year this equates to 405 hours released from unnecessary first assessment visits providing additional hours to focus on those patients with the greatest needs. Over a year hours released equates to a total of 90 appropriate first visits.

In addition the triage team now hold a telephone caseload which consists of patients with less complex needs and those being supported towards discharge from service. Before the introduction of this caseload each of these patients would have been supported in their home by a CNS. It can therefore be realistically argued that the telephone triage caseload is in addition preventing routine review visits. To attribute



## Impact on staff wellbeing

It was hoped that the innovations introduced would also result in a reduction in additional hours worked and overall sickness levels for the CNS team as this can enhance staff resilience. Table 4 however demonstrates that this has not occurred.

Table 4: Days lost to sickness and additional hours worked

	1.4.13 - 31.3.14	1.4.14 . 31.3.15	Difference in hours
	116	148	+ 32

## **Changes to the on-call process**

Changes to the on call process have also been made. This is directed to staff within the inpatient unit. Skilled nursing staff within the inpatient unit



enables us to begin to demonstrate the value of this activity could be having for our wider health care colleagues-

## Key costs of the innovations

To assess the overall economic impact of the raft of innovations introduced it is also necessary to take into account the overarching costs incurred. Costs listed are based on:

The teams experiences of introducing the changes to practice i.e. planning time, monitoring time, re-print costs

Salary costs which were:

- Staff nurse hourly rate (with NHS on costs) £14.48
- CNS hourly rate (with NHS on costs) £24.13

Costs can be broken down per activity as detailed below:

Planning time (start-up costs- not recurring):

Activity	Detail	Cost
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Indirect costs:

Activity	Detail	Cost
Increased admin support	7.5 hours per week	£68.37
Increased postal costs	Additional letters to patients at time of referral and discharge	Unable to quantify

Redeployment of staff resources (ongoing cost)

Activity	Detail	Cost
Geographical team meetings	Each GP attached CNS attends 1 meeting per month for 1 hour over a 1 year period	£3,474,72

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sickness have also increased during the time period examined (an additional 32 hours being lost to sickness). As part of this work stream was aimed at improving team resilience and preventing burnout there is clearly more work to be done.

It is envisaged that the team will continue to refine and build upon the changes to practice introduced. For the wider organisation the results of this report will be used to inform on-going strategy development work and it is envisaged at this time that the role of triage is likely to be extended across the organisation so that the benefits experienced by the CNS team can be replicated within other departments.



## **Appendix 1:**

### **Case study scenario demonstrating the impact of triage assessment and changes to the on call process**

#### **Prior to the innovations**

Mrs N was referred to the community service. Diagnosed with advanced breast cancer she was about to commence chemotherapy but was referred for pain control. The allocated CNS undertook a first assessment and agreed a management plan with Mrs N and her husband. This involved the titration of analgesics. Mrs N was visited weekly by her CNS who supported her as her analgesics were gradually increased from paracetamol to a opioid. As chemotherapy commenced Mrs N was still in pain. This reached crisis point, Mrs N became very distressed and called an out of hours Doctor and an injection of strong opiates was given. Further follow up visits were required by the CNS to increase the opiate dose to a point where pain was fully controlled.

and costs incurred. The total cost of CNS interventions in this situation would have

## Appendix 2: Levels of complexity for a sample of CNS's over a one week period

CNS 1:

<b>Patient Status</b>	<b>Number logged</b>
Stable	1
Unstable	8
Deteriorating	4
Dying	0

CNS 2:

<b>Patient Status</b>	<b>Number logged</b>
Stable	2
Unstable	22
Deteriorating	2
Dying	0

CNS 3:

<b>Patient Status</b>	<b>Number logged</b>
Stable	0
Unstable	14
Deteriorating	7
Dying	0

CNS 4:

<b>Patient Status</b>	<b>Number logged</b>
Stable	0
Unstable	17
Deteriorating	5
Dying	0

CNS 5:

<b>Patient Status</b>	<b>Number logged</b>
Stable	4
Unstable	23
Deteriorating	14
Dying	4



Data listed shows consistent targeting of activity within the patients with most complex needs whose condition is unstable or deteriorating. This was one of the aims of the service redesign- to enable the CNS team to spend more time with those patients with greatest need.

## St Richard's Hospice Community CNS Service

### Investment

Set up costs: £1456.40

On-going yearly costs:  
£14,240.11

Costs consist of:

1. Planning time
2. Resources (for patients and staff)
3. Increased administration support
4. Realignment of staff into geographical teams
5. Refocus of services i.e. on call is filtered through the inpatient unit

### The history

Specialist community CNS service in South Worcestershire  
Well established- consistent referrals from all areas

### Pressure points

Referral numbers increasing  
Complexity increasing  
High caseload numbers  
Consistent additional hours worked  
Ineffective use of existing resources  
Unnecessary visits where being undertaken  
Need for increased peer support as high levels of stress  
Time limited for complex patients

### Action

3 key innovations including:

Expansion of triage, proactive caseload management and changes to on call process

For those using the service

Enhanced access 24/7- via changes to on-call provision and released capacity

Increased choice. 30 patients over a 4 month period where able to choose not to see a CNS at home

An average of 10 patients per month had a prescription written within their home by a CNS reducing the need for GP review.

For St Richard's Hospice

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